

PLAN DESIGN AND BENEFITS - PPO HSA HDHP \$2,300 100/50

PLAN FEATURES	PREFERRED CARE	NON-PREFERRED CARE
Deductible (per calendar year)	\$2,300 Individual \$4,600 Family	\$2,300 Individual \$4,600 Family
<p>Unless otherwise indicated, the Deductible must be met prior to benefits being payable. All covered expenses accumulate separately toward the preferred and non-preferred Deductible. Once the Family Deductible is met, all family members will be considered as having met their Deductible for the remainder of the calendar year.</p>		
Member Coinsurance (applies to all expenses unless otherwise stated)	0%	50%
Payment Limit (per calendar year, includes deductible)	\$5,500 Individual \$11,000 Family	\$5,500 Individual \$11,000 Family
<p>All covered expenses accumulate separately toward the preferred and non-preferred Payment Limit. All copays, deductibles and coinsurance (including prescription drugs and self injectables) except Amounts Over Allowable and Failure to Pre-Certify penalty Amounts may be used to satisfy the Payment Limit. Once the Family Payment Limit is met, all family members will be considered as having met their Payment Limit for the remainder of the calendar year.</p>		
Lifetime Maximum (per member lifetime, Preferred and Non-Preferred combined)	\$2,000,000	
Payment for Non-Preferred Care	Not Applicable	Recognized Charge*
Primary Care Physician Selection	Not Applicable	Not Applicable
<p>Certification Requirements Certification for certain types of Non-Preferred care must be obtained to avoid a reduction in benefits paid for that care. Certification for Hospital Admissions, Treatment Facility Admissions, Convalescent Facility Admissions, Home Health Care, and Hospice Care is required. Benefits will be reduced by \$400 per occurrence if Certification is not obtained.</p>		
Referral Requirement	None	None
PHYSICIAN SERVICES	PREFERRED CARE	NON-PREFERRED CARE
Office Visits to Non-Specialist Includes services of an internist, general physician, family practitioner or pediatrician for routine care as well as diagnosis and treatment of an illness or injury.	0% after deductible	50% after deductible
Specialist Office Visits	0% after deductible	50% after deductible
Maternity OB Visits	0% after deductible	50% after deductible
Surgery (in office)	0% after deductible	50% after deductible
Allergy Testing & Treatment (given by a physician)	0% after deductible	50% after deductible
Allergy Injections (not given by a physician)	0% after deductible	50% after deductible
PREVENTIVE CARE	PREFERRED CARE	NON-PREFERRED CARE
Routine Adult Physical Exams / Immunizations Age and frequency schedules may apply Limited to \$300 per member maximum benefit every 12 months. Preferred and Non Preferred Combined	\$20 copay; deductible waived	50% after deductible

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Well Child Exams / Immunizations Age and frequency schedules may apply	\$20 copay; deductible waived	50% after deductible
Routine Gynecological Exams Includes Pap smear and related lab fees One routine exam(s) per 365 days.	\$20 copay; deductible waived	50% after deductible
Routine Mammograms One baseline mammogram for females age 35-39; and one annual mammogram for females age 40 and over.	\$20 copay; deductible waived	50% after deductible
Routine Digital Rectal Exams / Prostate Specific Antigen Test For covered males age 40 and over.	Member cost sharing is based on the type of service performed and the place rendered	50% after deductible
Colorectal Cancer Screening For all members age 50 and over. Frequency schedule applies.	Member cost sharing is based on the type of service performed and the place rendered	50% after deductible
Routine Vision and Hearing Exams Covered only as part of a routine physical exam	Covered as part of a routine physical exam	Covered as part of a routine physical exam
DIAGNOSTIC PROCEDURES	PREFERRED CARE	NON-PREFERRED CARE
Outpatient Diagnostic Laboratory and X-ray If performed as a part of a physician's office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing. If performed in the outpatient hospital department, payable under outpatient hospital plan provisions.	0% after deductible	50% after deductible
Complex Imaging Services Precertificatoin required. Including, but not limited to, MRI, MRA, PET and CT Scans and any other outpatient diagnostic imaging service costing over \$500.	0% after deductible	50% after deductible
EMERGENCY MEDICAL CARE	PREFERRED CARE	NON-PREFERRED CARE
Urgent Care Provider	0% after deductible	20% after deductible
Non-Urgent Use of Urgent Care Provider	Not Covered	Not Covered
Emergency Room Copay waived if admitted	0% after deductible	Paid as Preferred Care
Non-Emergency care in an Emergency Room	Not Covered	Not Covered
Emergency Ambulance	0% after deductible	Paid as Preferred Care

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HOSPITAL CARE	PREFERRED CARE	NON-PREFERRED CARE
Inpatient Coverage Including maternity prenatal, delivery and postpartum & transplants If transplant is performed through an [Institute of Excellence® or National Medical Excellence® facility, benefits would be paid at the preferred level. If procedure is not performed through Institutes of Excellence® or National Medical Excellence® facility, benefits would be paid at the non-preferred level.	0% after deductible	50% after deductible
Outpatient Surgery Provided in an outpatient hospital department	0% after deductible	50% after deductible
Outpatient Surgery Provided in a freestanding surgical facility	0% after deductible	50% after deductible
Outpatient Hospital Services other than Surgery Including, but not limited to, lab, x-ray, physical therapy, speech therapy, occupational therapy, spinal manipulation, dialysis and radiation therapy	0% after deductible	50% after deductible
MENTAL HEALTH SERVICES	PREFERRED CARE	NON-PREFERRED CARE
Inpatient Limited to 15 days per member per calendar year. Preferred and Non-Preferred combined.	0% after deductible	50% after deductible
Outpatient Limited to 20 visits per member per calendar year. Preferred and Non-Preferred combined.	0% after deductible	50% after deductible
ALCOHOL / DRUG ABUSE SERVICES	PREFERRED CARE	NON-PREFERRED CARE
Inpatient Detoxification Limited to 3 days per admission, 2 admissions per lifetime. Preferred and Non-Preferred combined.	0% after deductible	50% after deductible
Outpatient Detoxification	Not Covered	Not Covered
OTHER SERVICES AND PLAN DETAILS	PREFERRED CARE	NON-PREFERRED CARE
Convalescent Facility (Skilled Nursing Facility) Limited to 30 days per member per calendar year. Preferred and Non-Preferred combined.	0% after deductible	50% after deductible
Home Health Care	0% after deductible	50% after deductible

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Infusion Therapy Provided in the home or physician's office	0% after deductible	50% after deductible Aetna pays up to \$50 per visit after deductible
Infusion Therapy Provided in an outpatient hospital department or freestanding facility	0% after deductible	50% after deductible Aetna pays up to \$50 per visit after deductible
Inpatient Hospice Care Limited to 30 days per member per calendar year. Preferred and Non-Preferred combined.	0% after deductible	50% after deductible
Outpatient Hospice Care Limited to 60 visits per member per calendar year. Preferred and Non-Preferred combined.	0% after deductible	50% after deductible
Private Duty Nursing - Outpatient	Not Covered	Not Covered
Outpatient Speech Therapy Limited to 20 visits per member per calendar year. Preferred and Non-Preferred combined.	0% after deductible	50% after deductible
Outpatient Physical and Occupational Therapy Limited to 20 visits per member per calendar year. Preferred and Non-Preferred combined.	0% after deductible	50% after deductible
Outpatient Spinal Manipulation Therapy (Chiropractic)	0% after deductible	50% after deductible
Durable Medical Equipment Maximum benefit of \$2,500 per member per calendar year. Preferred and Non-Preferred combined.	0% after deductible	50% after deductible
Diabetic Supplies not obtainable at a pharmacy	Covered same as any other medical expense	Covered same as any other medical expense
Contraceptive drugs and devices not obtainable at a pharmacy Includes coverage for contraceptive visits	Covered same as any other medical expense	Covered same as any other medical expense
FAMILY PLANNING	PREFERRED CARE	NON-PREFERRED CARE
Infertility Treatment Covered only for the diagnosis and treatment of the underlying medical condition	Member cost sharing is based on the type of service performed and the place rendered	50% after deductible
Voluntary Sterilization Including tubal ligation and vasectomy	Member cost sharing is based on the type of service performed and the place rendered	50% after deductible

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PHARMACY - PRESCRIPTION DRUG BENEFITS	PARTICIPATING PHARMACIES	NON-PARTICIPATING PHARMACIES
Prescription drug calendar year deductible Must be satisfied before any prescription drug benefits are paid	Integrated Medical/Rx Deductible	Integrated Medical/Rx Deductible
All covered pharmacy expenses accumulate separately toward the preferred and non-preferred pharmacy deductible. Unless otherwise indicated, the pharmacy deductible must be met prior to pharmacy benefits being payable.		
Retail Up to a 30-day supply, includes insulin.	\$20 copay for generic drugs, \$40 copay for brand name formulary drugs, and \$60 copay for brand name non-formulary drugs	20% of submitted cost after \$20 copay for generic drugs, \$40 copay for brand name formulary drugs, and \$60 copay for brand name non-formulary drugs
Mail Order Delivery 31-90 day supply, includes insulin.	\$40 copay for generic drugs, \$80 copay for brand name formulary drugs, and \$120 copay for brand name non-formulary drugs	Not Covered
Self-Injectables (retail and mail order, excludes insulin, does accumulate toward payment limit)	20% after deductible for formulary and non-formulary drugs	50% after deductible for formulary and non-formulary drugs
Mandatory Generic with DAW override (MG w/DAW Override) - The member pays the applicable [copay] [coinsurance] only, if the physician requires brand. If the member requests brand when a generic is available, the member pays the applicable [copay] [coinsurance] plus the difference between the generic price and the brand price.		
Plan includes: Contraceptive drugs and devices obtainable from a pharmacy and diabetic supplies obtainable from a pharmacy and lifestyle/performance enhancing drugs (6 pills per month).		
Precertification included and 90 day Transition of Care (TOC) for Precertification included.		

*Payment for Non-Preferred facility care is determined based upon Aetna's Allowable Fee Schedule, which is subject to change. Payment for other Non-Preferred care is determined based upon the negotiated charge that would apply if such services or supplies were received from a Preferred Provider. These charges are referred to in your plan documents as "recognized" charges.

What's Not Covered

This plan does not cover all health care expenses and includes exclusions and limitations. Members should refer to their plan documents to determine which health care services are covered and to what extent. The following is a partial list of services and supplies that are generally *not covered*. **However, your plan documents may contain exceptions to this list based on state mandates or the plan design or rider(s) purchased.**

- All medical or hospital services not specifically covered in, or which are limited or excluded in the plan documents
- Charges related to any eye surgery mainly to correct refractive errors
- Cosmetic surgery, including breast reduction
- Custodial care
- Dental care and x-rays
- Donor egg retrieval
- Experimental and investigational procedures
- Hearing aids

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- Infertility services, including, but not limited to, artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI and other related services, unless specifically listed as covered in your plan documents
- Nonmedically necessary services or supplies
- Orthotics
- Over-the-counter medications and supplies
- Reversal of sterilization
- Services for the treatment of sexual dysfunction or inadequacies, including therapy, supplies, counseling and prescription drugs
- Special duty nursing
- Treatment of those services for or related to treatment of obesity or for diet or weight control

Pre-existing Conditions Exclusion Provision

This plan imposes a pre-existing conditions exclusion, which may be waived in some circumstances (that is, creditable coverage) and may not be applicable to you. A pre-existing conditions exclusion means that if you have a medical condition before coming to our plan, you might have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis or treatment was recommended or received or for which the individual took prescribed drugs within six months.

Generally, this period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, the six month period ends on the day before the waiting period begins. The exclusion period, if applicable, may last up to 12 months from your first day of coverage, or, if you were in a waiting period, from the first day of your waiting period.

If you had less than six months of creditable coverage immediately before the date you enrolled, your plan's pre-existing conditions exclusion period will be reduced by the amount (that is, number of days) of that prior coverage.

In order to reduce or possibly eliminate your exclusion period based on your creditable coverage, you should provide us a copy of any Certificates of Creditable Coverage you have. Please contact your Aetna Member Services representative at 1-888-802-3862 for PPO and 1-888-702-3862 for HMO/CPOS if you need assistance in obtaining a Certificate of Creditable Coverage from your prior carrier or if you have any questions on the information noted above.

The pre-existing condition exclusion does not apply to pregnancy nor to a child under age 18, who is enrolled in the plan within 31 days after birth, adoption, or placement for adoption. Note: For late enrollees, coverage will be delayed until the plan's next open enrollment; the pre-existing exclusion will be applied from the individual's effective date of coverage.

This material is for informational purposes only and is neither an offer of coverage nor medical advice. It contains only a partial, general description of plan benefits or programs and does not constitute a contract. Aetna does not provide health care services and, therefore, cannot guarantee results or outcomes. Consult the plan documents (i.e. Group Insurance Certificate and/or Group Policy) to determine governing contractual provisions, including procedures, exclusions and limitations relating to the plan. With the exception of Aetna Rx Home Delivery, all preferred providers and vendors are independent contractors in private practice and are neither employees nor agents of Aetna or its affiliates. Aetna Rx Home Delivery, LLC, is a subsidiary of Aetna Inc. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change without notice.

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Some benefits are subject to limitations or visit maximums. Certain services require precertification, or prior approval of coverage. Failure to precertify for these services may lead to substantially reduced benefits or denial of coverage. Some of the benefits requiring precertification may include, but are not limited to, inpatient hospital, inpatient mental health, inpatient skilled nursing, outpatient surgery, substance abuse (detoxification, inpatient and outpatient rehabilitation). When the Member's preferred provider is coordinating care, the preferred provider will obtain the precertification. Precertification requirements may vary.

Depending on the plan selected, new prescription drugs not yet reviewed by our medication review committee are either available at the highest copay under plans with an open formulary, or excluded from coverage unless a medical exception is obtained under plans that use a closed formulary. They may also be subject to precertification or step-therapy. Non-prescription drugs and drugs in the Limitations and Exclusions section of the plan documents (received after enrollment) are not covered, and medical exceptions are not available for them. Aetna Rx Home Delivery, LLC, is a licensed pharmacy providing mail-order pharmacy services. Aetna's negotiated reimbursement rates with Aetna Rx Home Delivery may be higher than Aetna Rx Home Delivery's cost of purchasing drugs and providing mail order services.

In prescription plans with copayment or coinsurance tiers, use of formulary drugs generally will result in lower costs to members. However, where the prescription plan utilizes copayments or coinsurance calculated on a percentage basis, there could be some circumstances in which a formulary drug would cost the member more than a non-formulary drug because (i) the negotiated pharmacy payment rate for the formulary drug may be more than negotiated pharmacy payment rate for the non-formulary drug, and (ii) rebates received by Aetna from drug manufacturers are not reflected in the cost of a prescription drug obtained by a member.

If your plan covers outpatient prescription drugs, your plan may include a drug formulary (preferred drug list). A formulary is a list of prescription drugs generally covered under your prescription drug benefits plan on a preferred basis subject to applicable limitations and conditions. Your pharmacy benefit is generally not limited to the drugs listed on the formulary. The medications listed on the formulary are subject to change in accordance with applicable state law. For information regarding how medications are reviewed and selected for the formulary, formulary information, and information about other pharmacy programs such as precertification and step-therapy, please refer to Aetna's website at Aetna.com, or the Aetna Medication Formulary Guide. Many drugs, including many of those listed on the formulary, are subject to rebate

arrangements between Aetna and the manufacturer of the drugs. Rebates received by Aetna from drug manufacturers are not reflected in the cost paid by a member for a prescription drug. In addition, in circumstances where your prescription plan utilizes copayments or coinsurance calculated on a percentage basis or a deductible, use of formulary drugs may not necessarily result in lower costs for the member. Members should consult with their treating physicians regarding questions about specific medications. Refer to your plan documents or contact Member Services for information regarding the terms and limitations of coverage.

Aetna Rx Home Delivery refers to Aetna Rx Home Delivery, LLC, a subsidiary of Aetna, Inc., that is a licensed pharmacy providing mail-order pharmacy services. Aetna's negotiated charge with Aetna Rx Home Delivery may be higher than Aetna Rx Home Delivery's cost of purchasing drugs and providing mail-order pharmacy services.

While this information is believed to be accurate as of the print date, it is subject to change.

Plans are provided by Aetna Life Insurance Company.